State of Wisconsin
Health Insurance Risk Sharing Plan (HIRSP)
1751 W. Broadway, PO Box 8961
Madison, Wisconsin 53708-8961
(800) 828-4777 or (608) 221-4551

Policy of the Wisconsin Health Insurance Risk Sharing Plan

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Important Notice

Policyholders should review their copy of the HIRSP application form. Omissions or misstatements in the application form could cause HIRSP to deny otherwise valid claims. Carefully check the form and write to HIRSP at the above address within 10 days of receiving this policy if:

(1) Any information shown on the form is not correct and complete.

(2) Any requested medical history has not been included.

HIRSP issued the insurance coverage based on the information given in the application.

If the *policyholder* is not satisfied with this policy, he or she may send it back to HIRSP, and HIRSP will return the premium. The *policyholder* must do this within 10 days after the postmark on the policy mailing. The policy will then be considered as never having been in force.

Part A. Please Read

Please refer to Definitions (Part E) if a word appears in *italics.*

HIRSP issues this policy to the *policyholder* in accordance with Wisconsin law. The paid premium

and completed application put this policy in force as of the *policy effective date*.

HIRSP may change the premium, change this policy, or decline renewal of this policy only as stated under Term and Renewal Agreement (Part B), Premium Change (Part C), and Policy Change (Part D).

Part B. Term and Renewal Agreement

Coverage starts on the *policy effective date* at 12:01 a.m. and ends on the *policy renewal date* at 12:01 a.m. Each time the *policyholder* renews the policy by paying the premium within the 31-day grace period, the new term begins when the old term ends.

HIRSP will terminate coverage the day the *policyholder:*

(1) Is eligible for employer-sponsored *creditable coverage,* which may include a group health plan or health insurance.

(2) Receives the *maximum lifetime benefit* under this policy.

(3) Is no longer a *resident* of Wisconsin.

(4) Is eligible for *Medicaid*.

(5) Receives a payment or reimbursement for a HIRSP premium, *HIRSP deductible,* or *HIRSP coinsurance* amount from a federal, state, county, or municipal government, or one of its agencies. This does not apply to the statutorily exempt state programs for the following:

(a) Vocational rehabilitation.

(b) Renal disease.

(c) Hemophilia.

(d) Cystic fibrosis.

(e) Maternal and child health services.

(f) Human immunodeficiency virus (HIV).

If this policy is canceled or not renewed, HIRSP will return the unused premium to the *policyholder*.

HIRSP must receive the premium on or before the date it is due or within the 31 days that follow.

Part C. Premium Change

The premium is subject to change. Premium changes are made only on the *policy renewal date* that coincides with, or next follows, the effective date of the new rate.

HIRSP can revise rates only if it does so on all policies, with the same provisions and benefits, issued to people of the same classification in the same geographic area. If HIRSP increases the premium rate for everyone in a plan by 25% or more, HIRSP will give *policyholders* 60 days advance notice.

Part D. Policy Change

Any provision of this policy is subject to change as mandated by the State of Wisconsin. *Policyholders* will receive written notice of any benefit reductions at least 60 days before the *policy renewal date*.

Part E. Definitions

The following words in *italics* have a specific meaning when used in this policy.

Allowed amount is the amount under Wisconsin Statutes that HIRSP would pay for *covered services* if *HIRSP coinsurance* and *HIRSP deductible*, as required under this policy, did not apply.

AODA means alcohol and other drug abuse.

Calendar year begins on January 1 and ends on December 31. In the *policyholder's* first year of HIRSP coverage, the calendar year begins on the *policy effective date* and ends on December 31 of the same year.

Coinsurance definitions are listed under *HIRSP coinsurance* and *Medicare coinsurance*.

Covered service is a *service* whose cost is eligible for reimbursement by HIRSP under the conditions set forth in this policy. HIRSP considers the expense for a covered service as incurred on the date the *policyholder* receives the *service*.

Creditable coverage is coverage under qualifying group health plans and insurance from any of the following:

(1) A group health plan.

(2) Health insurance coverage.

(3) *Medicare* Parts A and B.

(4) *Medicaid*.

(5) TriCare, formerly the Civilian Health and Medical Plan of the Uniformed Services (CHAMPUS).

(6) Civilian Health and Medical Plan of the Veterans Administration (CHAMPVA).

(7) A medical care program of the federal Indian health service or of an American Indian tribal organization.

(8) A state health benefits risk pool.

(9) A federal employee health plan.

(10) A public health plan.

(11) A Peace Corps health plan.

Custodial care is care designed to safeguard or assist the *policyholder* in activities of daily living. It does not require the continuing attention of trained medical personnel such as *Medicaid*-certified registered nurses and licensed practical nurses. Custodial care includes those *services* that constitute personal care such as:

(1) Help in walking and getting in and out of bed.

(2) Assistance in bathing, dressing, feeding, and using the toilet.

(3) Preparation of special diets.

(4) Supervision of medication that usually can be self-administered.

(5) Housekeeping, shopping, and homemaker services.

Care may be custodial even though it involves the use of technical medical skills if such skills can be easily taught to a layperson.

Deductible definitions are listed under *HIRSP deductible* and *Medicare deductible*.

DHFS is the Wisconsin Department of Health and Family Services, which administers HIRSP.

Disposable medical supplies are items that meet all of the following conditions:

(1) Have a very limited life expectancy and are consumable, expendable, disposable, or not durable.

(2) Serve primarily a medical purpose.

(3) Generally are not useful to a person in the absence of illness or injury.

(4) Are suitable for use in the *policyholder's* residence.

(5) Are *medically necessary and appropriate* and *reasonable* for treating the *policyholder's* illness or injury, or for improving the function of a malformed body member.

Durable medical equipment is equipment that meets all the following conditions:

(1) Can withstand repeated use. HIRSP does not consider prosthetics and orthotics to be durable medical equipment.

(2) Serves primarily a medical purpose. Equipment typically used for nonmedical purposes is not durable medical equipment even though it may have a medically related use (e.g., equipment used for environmental control, comfort or convenience, or physical fitness).

(3) Generally is not useful to a person in the absence of illness or injury.

(4) Is suitable for use in the *policyholder's* residence.

(5) Is *medically necessary and appropriate* and *reasonable* for treating the *policyholder's* illness or injury, or for improving the function of a malformed body member.

Eligible individual means an individual who meets **all** of the following:

(1) The aggregate of the individual's periods of *creditable coverage* is 18 months or more.

(2) The most recent period of *creditable coverage* was under a group health plan, government plan, or church plan.

(3) The individual does not currently have *creditable coverage* and is not currently eligible for a group health plan or *Medicaid*.

(4) The most recent *creditable coverage* was not terminated due to fraud, intentional misrepresentation, or failure to pay premium.

(5) The individual elected continuation coverage offered through a group health plan and exhausted the coverage.

(6) The individual has not had a break in insurance coverage greater than 63 days.

Emergency means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain. The condition must be severe enough to lead a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

(1) Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her fetus.

(2) Serious impairment to the person's bodily functions.

(3) Serious dysfunction of one or more of the person's body organs or parts.

If the *policyholder* receives emergency *services* from a *provider* who is not *Medicaid* certified, HIRSP will allow retroactive certification to cover the *services*.

Experimental means the use of any *service* for a specific illness or injury that is experimental or investigative in nature. A *service* is considered experimental when the HIRSP Medical Review Department has determined that the medical community does not generally recognize the *service* as effective or proven for the condition for which it is being used. A *service* may be considered by the HIRSP Medical Review Department to be experimental in one setting or institution, but effective, proven, and non-experimental in another depending on the experience, quality, and procedures used in a given institution. The HIRSP Medical Review Department resolves questions relative to the experimental or non-experimental nature of a procedure based on:

(1) Judgment of the medical community (see the definition for *generally accepted standards of medical practice*).

(2) The extent to which *Medicare* and private health insurers recognize and cover a *service*.

(3) The current judgment of experts in the applicable medical specialty area.

Generally accepted standards of medical practice means a *service* for a specific illness or injury, which, after consulting available medical resources, HIRSP determines to be generally accepted by the United States medical community. The sources HIRSP consults may include any or all of, but are not limited to, the following:

(1) Independent consulting health care professionals.

(2) Medical literature such as the "New England Journal of Medicine," the "Journal of the American Medical Association," or "Lancet."

(3) Position papers and guidelines of professional organizations and associations.

(4) Recent editions of commonly used medical specialty texts.

(5) Recent decisions of regulatory agencies such as the U.S. Food and Drug Administration (FDA).

(6) Assessment reports such as the Consensus Conference Statements released by the National Institute of Health (NIH) and the Clinical Practice Guidelines published by the Agency for Health Care Policy and Research (HCPR).

HIRSP coinsurance is the percentage of the HIRSP *allowed amount* for which the *policyholder* is responsible.

HIRSP deductible is a defined amount for which the *policyholder* is responsible before HIRSP will consider payment for a *covered service*.

Home health care agency means a *Medicaid*-certified *provider* of home health that provides skilled nursing *services* at the *policyholder's* place of residence.

Hospital means **any** of the following places certified by *Medicaid:*

(1) Licensed or recognized as a general hospital.

(2) Operated for the care and treatment of resident inpatients with a laboratory and X-ray facility and a registered nurse always on duty.

(3) Recognized as a general hospital by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

(4) Certified as a hospital by *Medicare*.

Not included is a hospital or institution or a part of such hospital or institution that is licensed or used principally as a clinic, continued or extended care facility, *skilled nursing care* facility, convalescent home, rest home, nursing home, or home for the aged.

In paying benefits for *AODA* and mental and nervous disorders, hospital also includes one of the following *Medicaid*-certified facilities:

(1) A special hospital licensed by the State of Wisconsin for the treatment of *AODA* and mental and nervous disorders.

(2) A public or private inpatient treatment facility approved by the *DHFS* for the treatment of alcoholism.

(3) A similar hospital or facility recognized by the JCAHO and licensed by the State of Wisconsin. Under no circumstances will such a place be a convalescent, nursing, or rest home.

Immediate family includes the *policyholder's* spouse, children, parents, grandparents, brothers, sisters, and their spouses.

Maximum lifetime benefit means the maximum dollar amount of benefits the *policyholder* may receive from HIRSP in his or her lifetime. See Maximum Lifetime Benefit (Part F) for more information.

Medicaid means Wisconsin Medicaid, which is a joint federal/state program that pays for medical *services* for eligible people as provided under Subsection IV of Chapter 49, Wisconsin Statutes.

Medicare means the health insurance program operated by the U.S. Department of Health and Human Services under Title 42 U.S. Code Section 1395 and Title 42 Code of Federal Regulation subchapter B.

Medicare coinsurance means the percentage of the amount *Medicare* allows for which the *Medicare* beneficiary is responsible.

Medicare deductible is a defined amount for which the *Medicare* beneficiary is responsible before *Medicare* will consider payment for a *covered service*.

Medically necessary and appropriate means a *service* that is required to prevent, identify, or treat a *policyholder's* illness, injury, or disability and meets all of the following standards:

(1) Consistent with the *policyholder's* symptoms or with prevention, diagnosis, or treatment of the *policyholder's* illness, injury, or disability.

(2) Provided consistent with standards of acceptable quality of care applicable to the type of *service,* the type of *provider,* and the setting in which the *service* is provided.

(3) Appropriate with regard to *generally accepted standards of medical practice*.

(4) Not medically contraindicated with regard to the *policyholder's* diagnoses, the *policyholder's* symptoms, or other medically necessary and appropriate *services* being provided to the *policyholder*.

(5) Of proven medical value or usefulness and not *experimental* in nature.

(6) Not duplicative with respect to other *services* being provided to the *policyholder*.

(7) Not solely for the convenience of the *policyholder,* the *policyholder's immediate family,* or a *provider.*

(8) The most appropriate supply or level of *service* that can safely and effectively be provided to the *policyholder.*

Outpatient treatment facility means a *Medicaid*-certified *provider:*

(1) Licensed or approved by the *DHFS*.

(2) Whose outpatient *services* meet *DHFS* standards.

(3) That provides the following outpatient *services* to prevent and treat disabling conditions:

(a) Comprehensive diagnostic and evaluation *services*.

(b) Outpatient care and treatment, precare, aftercare, *emergency* care, rehabilitation, and supportive transitional *services.*

(c) Professional consultation.

Examples of outpatient treatment facilities include, but are not limited to, psychiatric facilities, ambulatory surgical centers, urgent care centers, rehabilitation centers, or *hospital* outpatient surgical centers.

Physician means a *Medicaid*-certified *provider* licensed to practice medicine and surgery, including a graduate of an osteopathic college who holds an unlimited license to practice medicine and surgery.

Policy effective date is the date the HIRSP policy takes effect, in accordance with the terms in this policy.

Policy renewal date is the day after the last day of the *policyholder's* coverage period under HIRSP.

Policyholder is a person covered by HIRSP.

Provider means a health professional who meets HIRSP's certification requirements to provide health care *services*. This person must be providing *services* within the scope of his or her practice.

Reasonable means that a *service* meets all the following conditions:

(1) Provides therapeutic benefits in an economic manner.

(2) Does not serve the same purpose as a *service* already available to the *policyholder.*

Resident means a person who has been legally domiciled in the State of Wisconsin for a period of at least 30 days or, with respect to an *eligible individual,* an individual who resides in this state. Legal domicile is established by living in this state and obtaining a Wisconsin driver's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return.

A child is legally domiciled in this state if the child lives in this state and at least one of the child's parents or a child's legal guardian is legally domiciled in this state.

A person with a developmental disability or another disability that prevents the person from obtaining a Wisconsin driver's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return is legally domiciled in this state by living in this state.

Service means a service, treatment, procedure, therapy, drug, device, or supply that a *policyholder* receives from a *provider.* It may or may not be a *covered service.*

Skilled nursing care means professional nursing *services* that meet all of the following conditions:

(1) Furnished under a *Medicaid*-certified *physician's* orders.

(2) Requires the skills of a *Medicaid*-certified registered nurse or licensed practical nurse to be safely and effectively performed.

(3) Provided either directly by or under the supervision of the registered nurse or licensed practical nurse.

Transitional treatment means *services* for the treatment of nervous or mental disorders or *AODA*. The *services* are provided to a *policyholder* in a manner less restrictive than inpatient *hospital services* but more intensive than outpatient *services*.

Part F. Maximum Lifetime Benefit

The *maximum lifetime benefit* is $1,000,000.00 per individual for all benefits paid during the *policyholder's* lifetime.

Part G. Pre-existing Injury or Illness Provisions

The benefits of this policy will not be payable for any *services* related to a pre-existing injury or illness during the six months following the *policy effective date*. Pre-existing injury or illness means a condition, whether physical or mental, regardless of the cause of the condition, which was diagnosed or for which medical advice, care, or treatment was recommended or received during the six months immediately preceding the *policy effective date*. This provision does not apply if the *policyholder* is an *eligible individual*.

Part H. HIRSP Plans

HIRSP offers two insurance plans.

Plan 1

Plan 1 is for people who are not eligible for *Medicare* and offers two choices of annual deductible levels. *Policyholders* may choose between Option A ($1,000 deductible) and Option B ($2,500 deductible).

Once each *calendar year, policyholders* may request a change between Option A and Option B. The requested change will be effective January 1 of the next *calendar year* if the *policyholder* notifies HIRSP before November 1 of the current *calendar year*.

Policyholders are required to notify HIRSP when they become eligible for *Medicare*.

Plan 2

Plan 2 ($500 deductible) is only for people who are eligible for *Medicare*.

Part I. Out-of-Pocket Costs

Out-of-pocket costs for *covered services* include *HIRSP deductible* and *HIRSP coinsurance*, subject to the individual and family out-of-pocket maximums described in this part of the HIRSP policy.

Deductible

The *HIRSP deductible* amount for which the *policyholder* is responsible each *calendar year* is as follows:

Plan 1

(a) Option A: $1,000.00 or a reduced *HIRSP deductible* based on the *policyholder's* household income.

(b) Option B: $2,500.00.

Plan 2

$500.00.

Amounts applied toward the *HIRSP deductible* during the last three months of a *calendar year* will also be applied to satisfy the *HIRSP deductible* for the new *calendar year*.

Coinsurance

The *HIRSP coinsurance* amount for which the *policyholder* is responsible each *calendar year* is as follows:

Plan 1

When the *policyholder* incurs expenses for *covered services* due to an injury or illness, HIRSP will pay 80% of its *allowed amount* once the *policyholder* has met his or her annual *HIRSP deductible*. The *policyholder* is responsible for the remaining 20% of the HIRSP *allowed amount*.

After the *policyholder* satisfies the out-of-pocket maximum, *HIRSP coinsurance* no longer applies for the remainder of the *calendar year*. HIRSP will then pay 100% of its rate for the *covered service* for the remainder of that *calendar year*.

Plan 2

HIRSP coinsurance does not apply.

Individual Out-of-Pocket Maximum

The *policyholder's* individual out-of-pocket maximum includes all amounts applied to *HIRSP deductible* and *HIRSP coinsurance* within a *calendar year*. The out-of-pocket maximum for which the *policyholder* is responsible is as follows:

Plan 1

(a) Option A: $2,000.00.

(b) Option B: $3,500.00.

Plan 2

$500.00.

Family Out-of-Pocket Maximum

When referring to the family out-of-pocket maximum, **family** means two or more of the following persons, or any combination thereof, who are insured under HIRSP: either or both spouses and all dependent children of either spouse.

The *policyholder's* family out-of-pocket maximum includes all amounts applied within a *calendar year* to *HIRSP deductible* and *HIRSP coinsurance* for a family under the same HIRSP plan. The family out-of-pocket maximum for which the family is responsible is as follows:

Plan 1

(a) Option A: $4,000.00.

(b) Option B: $7,000.00.

Plan 2

$1,000.00.

Part J. Reimbursement

General Reimbursement

HIRSP uses several methods for reimbursing claims, such as:

(1) Outpatient *hospital* claims by a percentage of charges. Some *services* are not included in these rates and need to be billed separately on the approved claim form.

(2) Inpatient *hospital* claims by rate per stay based on diagnosis-related group. Some *services* are not included in these rates and need to be billed separately on the approved claim form.

(3) *Skilled nursing care* facility claims by rate per day. Some *services* are not included in these rates and need to be billed separately on the approved claim form.

(4) Most other *services* by a specific rate per *service*.

Medicare Deductible and Coinsurance (Plan 2)

For a Plan 2 *policyholder,* HIRSP will pay *Medicare deductible* and *Medicare coinsurance* as long as the *service* is a HIRSP *covered service*. HIRSP's *covered services,* which are listed in this policy, may not necessarily be the same as a *Medicare*-covered benefit.

If the *policyholder* chooses not to pay the *Medicare* Part B premium, HIRSP's reimbursement will not exceed 20% of the HIRSP *allowed amount*.

Assignment of Benefits

HIRSP will issue payment either to the *Medicaid*-certified *provider* or *policyholder* according to information provided on the claim form. If the claim form does not contain instructions for who should receive payment, HIRSP, at its option, will pay the *policyholder* or the *provider* of the *services*.

Any benefits payable to the *policyholder* that are unpaid at the time of his or her death will be paid to the *policyholder's* beneficiary.

If any benefits are payable to the *policyholder's* estate or anyone showing proof of primary beneficial interest, HIRSP may pay up to $1,000.00 to anyone whom it finds entitled to the payment. Payment made in good faith shall fully discharge HIRSP to the extent of the payment.

Payment in Full

Providers are prohibited under law by Section 149.14(4m), Wisconsin Statutes, from billing the *policyholder* for the difference between the charge for a *covered service* and the amount paid by HIRSP, except for *HIRSP coinsurance* and *HIRSP deductible*.

Part K. Major Medical Benefits

To be covered by HIRSP, the following major medical benefits, like all benefits listed in this policy, must be provided by *Medicaid*-certified *providers.*

Subject to Exclusions and Limitations (Part T), HIRSP's major medical benefits are:

(1) *Hospital* room and board and any other *hospital services*.

(2) Medical-surgical *services*, including both in-*hospital* and out-of-*hospital* medical and surgical *services*, diagnostic *services*, anesthesia *services*, and consultation *services*.

(3) *Hospital* inpatient and outpatient treatment of kidney disease, including dialysis, transplantation, and donor-related *services*. The following conditions apply:

(a) Benefits are in lieu of any other *hospital* benefits for kidney disease payable under this policy.

(b) Total benefits payable under this item, including any other kidney disease benefits the *policyholder* may receive from this policy, cannot exceed $30,000.00 in any one *calendar year*.

(4) *Services* performed by a *Medicaid*-certified physical therapist, occupational therapist, speech and language pathologist, certified occupational therapy assistant, and physical therapy assistant.

(5) Processing charges for blood including, but not limited to, the cost of collecting, testing, fractioning, and distributing blood.

(6) Use of radium or other radioactive materials.

(7) Diagnostic X-rays and laboratory tests.

(8) Oxygen.

(9) Anesthesia.

(10) Rental or purchase, whichever is more cost effective, of *durable medical equipment* and purchase of batteries required to operate *durable medical equipment*.

(11) Purchase of prescription surgical compression stockings of 12 to 15 millimeters mercury (mmHg) compression (surgical weight) at the ankle or greater. The number of pairs covered is determined by what HIRSP determines is ***medically necessary and appropriate*** (normally six a year), but only two pairs may be issued at one time. The *policyholder* will pay the difference of the cost of any product over and above that which HIRSP determines is ***medically necessary and appropriate***.

(12) Prostheses other than dental.

(13) *Disposable medical supplies,* including:

(a) Colostomy, urostomy, and ileostomy appliances.

(b) Diabetic urine and blood testing supplies.

(c) Dressings.

(d) Elastic bandages and tubular elastic bandages when billed by a *Medicaid*-certified home care *provider* or the *physician's* office.

(e) Gastric feeding/enteral sets and supplies. HIRSP does not cover over-the-counter food or nutritional products.

(f) Catheters and irrigation apparatus.

(g) Parenteral supplies.

(h) Tracheostomy and endotracheal care supplies.

(i) Ventilator supplies.

(j) Transcutaneous Electrical Nerve Stimulation (TENS) supplies if HIRSP covered the TENS unit.

(14) Transportation provided by a licensed ambulance *provider* to the nearest *hospital* or *skilled nursing care* facility qualified to treat the condition. HIRSP does not cover *services* provided by a specialized medical vehicle (SMV).

(15) Chiropractic *services* when provided within the scope of the *provider's* license.

(16) Diagnostic procedures and surgical or nonsurgical treatment for the correction of temporomandibular joint (TMJ) disorders if the following conditions are met:

(a) The condition is caused by congenital, developmental, or acquired deformity, disease, or injury.

(b) The *service* is *reasonable* and appropriate for the diagnosis or treatment of the condition, under the accepted standards of the profession of the health care *provider* rendering the *service*.

(c) The purpose of the *service* is to control or eliminate infection, pain, disease, or dysfunction.

HIRSP covers prescribed intraoral splint therapy devices.

(17) Oral surgery for partial or completely unerupted, impacted teeth.

(18) Oral surgery with respect to tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(19) *Hospital* or ambulatory surgery center charges and anesthetics provided for dental care for a *policyholder* if he or she meets any of the conditions below:

(a) The *policyholder* is under the age of 5.

(b) The *policyholder* has a chronic disability that is attributable to a mental and/or physical impairment that results in substantial functional limitation in an area of major life activity, and the disability is likely to continue indefinitely.

(c) The *policyholder* has a medical condition that requires hospitalization or general anesthesia for dental care.

(20) Papanicolaou (Pap) tests, pelvic exams, or associated laboratory fees when a *Medicaid*-certified *physician,* nurse-midwife, or a nurse practitioner performs the test or examination.

(21) Breast reconstruction of the affected tissue incident to a mastectomy.

(22) Initial purchase of eyeglasses or contact lenses for aphakia or keratoconus and initial purchase following cataract surgery.

(23) Blood lead screening tests for *policyholders* under 6 years of age.

(24) Gastrointestinal surgery for obesity.

(25) Biofeedback for *policyholders* at least 18 years old, only when all of the following conditions are met:

(a) Provided by a *Medicaid*-certified *physician,* physical therapist, or occupational therapist.

(b) Used for treatment of muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness and urinary incontinence.

(26) Orthoptics (eye exercise training) when used for convergence insufficiency, strabismus, and amblyopia. HIRSP covers a maximum of two visits.

(27) Abortions, only when the *physician* determines the procedure is directly and medically necessary to save the life of the woman.

Part L. Skilled Nursing Care Facility Benefits

To be covered by HIRSP, the following skilled nursing care benefits, like all benefits listed in this policy, must be provided by *Medicaid*-certified *providers.*

Subject to Exclusions and Limitations (Part T), HIRSP's *skilled nursing care* facility benefits are stated below.

HIRSP will pay for *skilled nursing care* to patients in a *skilled nursing care* facility only if the confinement is upon the specific recommendation and under the supervision of a *physician*. HIRSP will pay for expenses incurred for *covered services* for confinement in a *skilled nursing care* facility for each covered period of confinement of up to 30 days.

A covered period of confinement with a *skilled nursing care* facility begins:

(1) At least 60 days after the *policyholder* was last confined in a *skilled nursing care* facility for *skilled nursing care* for the injury or illness that caused the prior confinement.

(2) Any time a confinement in a *skilled nursing care* facility is not related to any cause of a previous confinement.

If the *policyholder* is enrolled in Plan 2, HIRSP will not pay for more than a total of 120 days in any one *calendar year*. This expense must be of the type reimbursable under *Medicare*.

Part M. Transplantation Benefits

To be covered by HIRSP, the following transplantation benefits, like all benefits listed in this policy, must be provided by *Medicaid*-certified *providers.*

Subject to Exclusions and Limitations (Part T), HIRSP's transplantation benefits are:

(1) Bone marrow/stem cell.

(2) Cornea.

(3) Heart.

(4) Heart/lung.

(5) Intestine.

(6) Kidney.

(7) Liver.

(8) Lung.

(9) Pancreas.

HIRSP will also pay donor benefits associated with donating the organ to the *policyholder*.

In addition to other limitations indicated in this policy, the following limitations apply:

(1) HIRSP will pay for one transplant per organ during the *policyholder's* lifetime, except as required for treatment of kidney disease.

(2) The organ must be from a human donor.

(3) HIRSP does not cover the purchase price of an organ that is sold, rather than donated, to the *policyholder*.

(4) HIRSP does not cover tissue and blood typing of potential or actual donors.

Part N. Home Care Benefits

To be covered by HIRSP, the following home care benefits, like all benefits listed in this policy, must be provided by *Medicaid*-certified *providers.*

Subject to Exclusions and Limitations (Part T), HIRSP's home care benefits are stated below.

HIRSP will pay the expenses incurred for *covered services* for *medically necessary and appropriate* home care *services* provided by or coordinated by a *home*

health care agency. Home care includes hospice *services* if those *services* are provided by or coordinated by a *home health care agency* that is licensed and certified to provide hospice *services*.

To be considered for payment, these *covered services* must meet the following criteria:

(1) The *services* must be included under a plan of home care, established and approved in writing, and revised at least every 62 days by the attending *physician*, unless the attending *physician* determines that a longer interval between reviews is sufficient.

(2) If there was hospitalization immediately prior to the start of home care, the *physician* who was the primary *provider* of *services* during hospitalization must initially approve the home care plan.

(3) The attending *physician* certifies that hospitalization or confinement in a *skilled nursing care* facility would be required if home care was not provided.

(4) Necessary care and treatment are not available from the *immediate family* or other people residing with the *policyholder* without causing undue hardship.

Home care includes the following *covered services:*

(1) Part-time or intermittent home nursing care by or under the supervision of a *Medicaid*-certified registered nurse.

(2) Part-time or intermittent home health aide *services* that are *medically necessary and appropriate* as part of the *policyholder's* home care plan. These *services* must be under the supervision of a *Medicaid*-certified registered nurse.

(3) Physical, respiratory, occupational, and speech therapy.

(4) Nutrition counseling provided by or under the supervision of a *Medicaid*-certified *physician*, registered nurse, pharmacist, or other *provider*. Such *services* must be *medically necessary and appropriate* as part of the home care plan.

(5) The evaluation of the need for, and development of, a plan by a *provider* who may be a registered nurse, physician assistant, or nurse practitioner for home care when approved or required by the attending *physician*.

(6) If necessary under the home care plan:

(a) *Disposable medical supplies,* drugs, and medications prescribed by a *provider*.

(b) Laboratory *services* by or on behalf of a *hospital*.

The above items are *covered services* to the same extent as if the *policyholder* had been hospitalized.

Home care benefits are limited to:

(1) 40 home care visits in a *calendar year* for Plan 1 *policyholders*.

(2) 365 home care visits in a *calendar year*, including home care visits covered by *Medicare,* for Plan 2 *policyholders*.

Up to four consecutive hours of home care in a 24-hour period or each visit by a member of a home care team is considered to be one home care visit.

Part O. Routine Mammogram Benefits

To be covered by HIRSP, the following routine mammogram benefits, like all benefits listed in this policy, must be provided by *Medicaid*-certified *providers.*

If a female *policyholder* incurs expenses for a routine mammogram, HIRSP will pay the following benefits:

(1) Two mammograms for women age 45 through 49, provided the woman has not had a mammogram within two years before each mammogram is performed. Benefits will be reduced to the extent any prior mammograms were obtained prior to obtaining coverage under this policy.

(2) One mammogram each *calendar year* for women age 50 and over.

Part P. Alcoholism, Drug Abuse, and Mental and Nervous Disorders Benefits

To be covered by HIRSP, the following *AODA* and mental and nervous disorders benefits, like all benefits listed in this policy, must be provided by *Medicaid*-certified *providers.*

Subject to Exclusions and Limitations (Part T), HIRSP's benefits for *AODA* and mental and nervous disorders are stated below.

Inpatient

HIRSP will pay the expenses incurred for inpatient *covered services* provided by a *Medicaid*-certified *physician* or under the supervision of or on referral from a *physician* for *AODA* and mental and nervous disorders. Inpatient *services* are provided to a patient in a *hospital* or any facility for which state law mandates benefits be paid. This includes psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation care. Benefits are payable as specified under Major Medical Benefits (Part K) and are limited to:

(1) 30 days per *calendar year* for treatment of *AODA*.

(2) 60 days per *calendar year* for mental and nervous disorder treatment.

Outpatient

Benefits for outpatient *AODA* and mental and nervous disorders are limited to $3,000.00 paid in a *calendar year*.

HIRSP will pay the expenses incurred for outpatient *covered services* provided by a *Medicaid*-certified *physician* or under the supervision of or on referral from a *physician* for *AODA* and mental and nervous disorders. Outpatient *services* are nonresidential *services* provided to the *policyholder* or, if to enhance the treatment, to the *policyholder's immediate family*. *Services* include partial hospitalization *services*, convulsive therapy, psychotherapy, and psychological testing. *Services* must be provided by any of the following:

(1) A program in an *outpatient treatment facility*. The program and the facility must be approved, established, and maintained according to the state law mandating benefits.

(2) A *physician* who has completed a residency in psychiatry, either in an *outpatient treatment facility* or the *physician's* office.

(3) A psychologist who is listed in the National Register of Health Service Providers in Psychology or a psychologist certified by the American Board of Professional Psychology.

HIRSP will pay the first $500.00 of the *allowed amount* of expenses incurred for *covered services* at 100% during any one *calendar year*. Expenses for *covered services* exceeding the first $500.00 are subject to *HIRSP deductible* and *HIRSP coinsurance*.

Transitional Treatment

Benefits for *transitional treatment* arrangements are limited to $3,000.00 paid in a *calendar year*. This is in addition to outpatient *hospital* benefits for *AODA* and mental and nervous disorders.

HIRSP will pay the expenses incurred for *covered services* for *transitional treatment* arrangements, which include the following levels of service:

(1) Mental health *services* for adults in a day treatment program offered by a *provider* certified by the *DHFS* under HFS 61.75, Wisconsin Administrative Code.

(2) Mental health *services* for children and adolescents in a day treatment program offered by a *provider* certified by the *DHFS* under HFS 61.81, Wisconsin Administrative Code.

(3) *Services* for persons with chronic mental illness provided through a community support program certified by the *DHFS* under HFS 63.03, Wisconsin Administrative Code.

(4) Residential treatment programs for alcohol or drug dependent persons or both, certified by the *DHFS* under HFS 61.60, Wisconsin Administrative Code.

(5) *Services* for *AODA* provided in a day treatment program certified by the *DHFS* under HFS 61.61, Wisconsin Administrative Code.

(6) Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine.

Transitional treatment arrangements are not subject to *HIRSP deductible* and *HIRSP coinsurance*.

Part Q. Diabetes Benefits

To be covered by HIRSP, the following diabetes benefits, like all benefits listed in this policy, must be provided by *Medicaid*-certified *providers.*

If the *policyholder* incurs expenses because of diabetes, HIRSP will pay the following:

(1) The installation, use, or purchase of an insulin infusion pump after the *policyholder* has used it for 30 days.

(2) Other *durable medical equipment* or *disposable medical supplies,* including insulin, for the treatment of diabetes. HIRSP covers some supplies only for diabetics.

(3) Expenses incurred for a diabetic outpatient self-management education program that meets the following criteria:

(a) Is taught or supervised by a *Medicaid*-certified *physician,* a registered nurse, a pharmacist, or other *provider*.

(b) Teaches diabetic patients and their *immediate families* the diabetic disease process and the daily diabetic therapy to avoid frequent *hospital* confinements and complications.

(c) Meets any standards by which the State of Wisconsin certifies or approves such programs.

(d) Does not include a program that is mainly for the purpose of weight reduction.

Part R. Drug Benefits

To be covered by HIRSP, the following drug benefits, like all benefits listed in this policy, must be provided by *Medicaid*-certified *providers.*

Subject to Exclusions and Limitations (Part T), HIRSP will pay benefits for prescription drugs and insulin prescribed by a *provider*. This includes drugs used for the treatment of AIDS infection.

Refill Policy

Refills of a prescription are a *covered service* if they meet the following criteria:

(1) Prescriptions for drugs that are not controlled substances (non-schedule drugs) are limited to the original dispensing plus 11 refills within 12 months. A new prescription is required after 12 months even if all refills have not been dispensed.

(2) Refills for drugs that are controlled substances with the potential for abuse (e.g., Schedule III, IV, and V drugs as defined in Sections 961.17-961.22, Wisconsin Statutes) are limited to the original dispensing plus five refills within six months. A new prescription is required after six months even if all refills have not been dispensed.

Part S. Maternity and Newborn Benefits

Maternity Benefits

HIRSP covers prenatal and postnatal *services* rendered by a *Medicaid*-certified *hospital, physician,* nurse practitioner, or nurse-midwife to a *policyholder* for normal pregnancy, complications of pregnancy, and miscarriage. Maternity *services* include ordinary nursery care of a newborn infant during the period of the mother's hospitalization following delivery.

Newborn Coverage

HIRSP will cover a newborn in the first 48 hours of life if one or both of its parents is a *policyholder*. To be insured after the second day, newborns are required to have their own HIRSP policy.

Within the first 60 days after the child's birth, the child will be automatically eligible for enrollment in HIRSP, unless the child is eligible for *Medicaid*. If the *policyholder* wants the child to receive HIRSP coverage, the *policyholder* is required to:

(1) Notify HIRSP to begin the child's coverage.

(2) Pay the full initial premium for the child's coverage.

After the first 60 days, but no later than one year after the child's birth, the *policyholder* may enroll the child in HIRSP. Coverage will begin from the date of birth if HIRSP receives all past-due premiums, plus an additional 5½% interest.

After one year, the child will be eligible for HIRSP only if the child meets HIRSP eligibility requirements, as outlined in Section 149.12, Wisconsin Statutes.

Part T. Exclusions and Limitations

HIRSP may exclude or limit any *service* that HIRSP determines is **not:**

(1) *Medically necessary and appropriate.*

(2) *Reasonable.*

(3) Provided in accordance with *generally accepted standards of medical practice.*

HIRSP does not cover the *services* listed below.

Inpatient Services Not Covered by HIRSP

(1) *Hospital* stays that are extended for reasons that are not *medically necessary and appropriate* (e.g., lack of transportation, lack of care giver, inclement weather, bed not available in another facility).

(2) An inpatient stay, if HIRSP determines that care could be provided effectively in a less acute care setting, such as a *skilled nursing care* facility.

(3) Take-home drugs and supplies dispensed at the time of *hospital* discharge that can reasonably be purchased on an outpatient basis.

Medical-Surgical Services Not Covered by HIRSP

(1) Unless otherwise stated in this policy as *covered services,* routine examinations, including:

(a) Physical examinations.

(b) Dental examinations.

(c) Examinations to determine the need for eyeglasses and hearing aids.

(d) Examinations requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, or by court order.

(2) Smoking cessation products, programs, treatments, drugs, or supplies when prescribed solely for smoking cessation.

(3) Food or liquid nutritional substances, including enteral nutritional products:

(a) On an outpatient basis.

(b) As an inpatient in a nursing home.

(4) Cosmetic or elective orthodontic care or general dental care, except as indicated under Major Medical Benefits (Part K).

(5) *Services* of blood donors and any fee for failure to replace the first three pints of blood provided to an eligible *policyholder* each *calendar year.*

(6) Treatment for obesity including:

(a) Weight loss programs including dietary and nutritional treatment in connection with obesity.

(b) Drugs prescribed for the *policyholder* solely for the purpose of weight loss.

(7) *Services* directed toward the care and correction of flat feet.

(8) Sublingual allergy immunotherapy (drops).

(9) Allergy testing such as environmental, challenge, provocative, and wrinkle.

(10) Clozapine management (e.g., phone consultations and transportation for blood

work). However, HIRSP will cover the cost of the drug and laboratory testing.

(11) Prolotherapy.

(12) Work-related preventive treatment (e.g., vaccinations for hepatitis or rabies).

(13) Chelation therapy except for the treatment of digitalis or heavy metal toxicity.

(14) *Services* for holistic medicine, including, but not limited to, homeopathic medicine.

(15) As separate charges, preoperative and postoperative surgical care, such as office visits for suture and cast removal, which commonly are included in the payment of the surgical procedure.

(16) *Services* for cosmetic or beautifying purposes. HIRSP, however, will cover reconstructive/corrective surgery for the repair or treatment of an injury, or a congenital or developmental body defect. Psychological reasons do not represent a medical or surgical necessity.

(17) *Services* related to sex transformation surgery.

(18) Acupuncture or similar methods.

(19) Ear lobe repair.

(20) Surgical and nonsurgical treatments for fertility, sterility, impotence, and reduced libido including:

(a) Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related *hospital*, professional, and diagnostic *services* and medications that are incidental to such insemination and fertilization methods.

(b) Donor sperm.

The diagnosis of infertility alone does not constitute an illness.

(21) Internal and external penile prostheses.

(22) Surrogate parenting and related *services*.

(23) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

(24) Amniocentesis, chorionic villus sampling (CVS), ultrasound, or other tests solely for sex determination.

Equipment Not Covered by HIRSP

(1) Hearing aids and related supplies (e.g., batteries).

(2) Devices used for impotency.

(3) Equipment that HIRSP determines is not medical in nature such as, but not limited to, air conditioners, air cleaners, humidifiers, physical fitness equipment, and alternative communication devices.

(4) Equipment, models, or devices that HIRSP determines are or have features over and above that which are *medically necessary and appropriate* or *reasonable* for the *policyholder*.

(5) Stair lifts and motor vehicles (e.g., cars, vans) or customization of vehicles, lifts and ramps for wheel chairs, and scooters.

(6) Equipment, devices, or supplies approved by the FDA but not yet determined by HIRSP to be *medically necessary and appropriate* or non-*experimental.*

Disposable Medical Supplies Not Covered by HIRSP

(1) Home testing and monitoring supplies other than diabetic supplies.

(2) TENS supplies when HIRSP did not cover the TENS unit.

(3) Supplies not listed under Major Medical Benefits (Part K) or any supply that is not *medically necessary and appropriate, reasonable,* or non-*experimental,* as determined by HIRSP.

Therapies Not Covered by HIRSP

(1) Vocational rehabilitation, including work hardening programs.

(2) *Services* used in educational or vocational training.

(3) Coma stimulation programs.

(4) Aqua therapy.

(5) Massage therapy.

(6) Physical fitness or exercise programs.

Drugs Not Covered by HIRSP

(1) Over-the-counter medications (except insulin).

(2) Prescription drugs that have an over-the-counter equivalent.

(3) Drugs classified as Less-Than-Effective (LTE) by the FDA, including:

(a) Compound drugs that contain an LTE drug.

(b) Compound prescriptions that result in drug combinations that the FDA considers LTE.

(4) Drugs that HIRSP determines are *experimental* or not *medically necessary and appropriate.* Such drugs include, but are not limited to:

(a) Human growth hormone when used for AIDS wasting or cachexia.

(b) Compounded drugs containing DHEA, 5-HT, Levodopa, L-Tryptophan, natural estrogen, natural progesterone, Nystatin, and testosterone.

(5) Drugs approved by the FDA but not yet determined by HIRSP to be *medically necessary and appropriate* or non-*experimental.*

(6) Bleaching agents, such as Melanex, Eldoquin, and Solaquin, that HIRSP considers to be cosmetic.

(7) Retin-A when used solely for cosmetic purposes.

(8) Rogaine and Propecia, or their medical equivalent.

(9) Appetite suppressants and drugs prescribed solely for the purpose of weight loss.

(10) Micronized progesterone (except medroxyprogesterone).

(11) Alcoholic beverages, even if prescribed for remedial or therapeutic reasons.

(12) Sex hormones related to sex transformation.

(13) Drugs used solely for the treatment of fertility, sterility, impotence, and reduced libido.

General Items Not Covered by HIRSP

(1) Expenses incurred before the *policy effective date* or after the policy cancellation date.

(2) Charges directly related to a HIRSP non-*covered service*. However, HIRSP covers *medically necessary and appropriate* treatment of a complication that resulted from a non-*covered service* if the treatment is a HIRSP *covered service*.

(3) *Services* that HIRSP determines are *experimental*. (This does not include drugs for the treatment of HIV infection.) The types of *services* that may fall into this category include, but are not limited to:

(a) New medical or biomedical technology.

(b) Methods of treatment by diet or exercise.

(c) New diagnostic and surgical methods or techniques.

(d) Transplants and implants of body organs, unless coverage is required by law or the procedure is no longer considered *experimental*.

(4) Physical therapy, occupational therapy, and speech therapy *services* made available to treat learning disabilities in school-aged children. As provided under federal and state laws, these *services* are available at no charge through the child's school district.

(5) Expenses incurred for treatment of an injury or illness that is payable under another policy of health care insurance, fixed indemnity, *Medicare*, or any other governmental program, except as otherwise provided by law.

(6) Expenses incurred for treatment of an injury or illness that is payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, liability insurance, or equivalent self-insurance policy.

(7) Expenses incurred for treatment of an injury or illness that is covered by workers' compensation or employers' liability laws.

(8) *Services* for any injury or illness as the result of war, declared or undeclared, enemy action or action of armed forces of the United States, or any state of the United States, or its allies, or while serving in the armed forces of any country.

(9) Personal comfort or convenience items, including, but not limited to, in-*hospital* television and telephone.

(10) The following personal supplies and hygiene products, which HIRSP considers to be nonmedical:

(a) Diapers, liners, and underpads.

(b) Incontinence pants, liners, and pads.

(c) Support hose.

(d) Ear plugs.

(11) *Services* that are personal, are not medical, or do not require a *physician's* prescription.

(12) *Services* whose provision is not within the scope of authorized practice of the institution or individual providing the *services*.

(13) Care that is primarily for *custodial* or domiciliary purposes that does not qualify as eligible *services* under *Medicare*.

(14) Charges for any missed appointment.

(15) Administrative costs incurred in providing HIRSP with medical records to process claims, including, but not limited to, labor, taxes, shipping and handling, and photocopying expenses.

(16) The following charges:

(a) State tax on goods and services.

(b) Shipping and handling.

(17) *Hospital* and nursing home bedhold days.

(18) *Services* provided by members of the *policyholder*'s *immediate family* or anyone else living with the *policyholder*.

(19) *Services* performed by means of a telephone call between a *physician* and a *policyholder*, including those in which the *physician* provides advice or instructions to or on behalf of a *policyholder*, or between or among *physicians* on behalf of the *policyholder*.

(20) Charges for, or in connection with, travel, except for ambulance transportation as outlined under Major Medical Benefits (Part K).

(21) As separate charges, transportation expenses incurred by a *physician*, including, but not limited to, time and mileage.

(22) Autopsies.

Part U. Subrogation

HIRSP shall be subrogated to the *policyholder's* rights or recovery for damages to the extent that benefits are provided under this policy for any illness or injury to the *policyholder* that was caused by the act of another person or organization. HIRSP will not recover damages unless the *policyholder's* entire loss compensable under the law is recovered from the third party or the third party's insurer. Third party means another person or organization.

Part V. Filing Claims

HIRSP will pay benefits for *covered services* submitted on a properly completed claim form. The *policyholder* or the *provider* must file the claim with HIRSP in **90 days** following the date the *services* were provided. If circumstances prevent the *policyholder* or *provider* from filing a claim within this time, HIRSP must receive the claim within **15 months** following the date the *services* were provided. Under extraordinary circumstances, HIRSP may consider claims received after this deadline.

HIRSP will issue written notice regarding the claim within 30 days of receiving the claim, unless special circumstances require more time.

Part W. Review and Grievance Process

If HIRSP denies an application or claim payment, the applicant or *policyholder* will receive directly from HIRSP a written notice of the denial, together with the specific reason for the denial.

An individual may request a review if he or she disagrees with HIRSP's decision to:

(1) Deny or terminate coverage.

(2) Deny or reduce payment of a claim.

(3) Deny an application for a subsidy of *HIRSP deductible* and/or premium.

HIRSP will not consider requests to review across-the-board premium rate increases. These rates are set based on HIRSP's budgetary requirements and conditions as established by state law.

A *policyholder* may request a review of the actions listed above according to the following procedure.

Review by Plan Administrator

If the *policyholder* or applicant disagrees with HIRSP's decision, the individual may request a review by the plan administrator. The individual has **60 days** after the date of HIRSP's decision to request in writing a further review by the plan administrator. To request the review, the *policyholder* must submit a written request including pertinent information such as name, identification number, date and place of service, and reason for the review.

Clearly indicate that the written request is for a review. This will help HIRSP process the request.

Mail the request for review to:

HIRSP
Appeals Department
PO Box 7062
Madison, WI 53707-7062

Upon receiving the request, the plan administrator will review the decision and either affirm, modify, or rescind it. The plan administrator will communicate this decision, and the reason for the decision, in a written response. The plan administrator has 10 days from receipt of a request for review to issue a letter of decision or a letter to the requester asking for more information.

Review by Grievance Committee

If the *policyholder* or applicant disagrees with the plan administrator's decision on the review, the individual may file a grievance. The individual has **30 days** after the date of the written results of the plan administrator's review to request in writing a further review by the HIRSP Grievance Committee. To file a grievance, the individual must submit a written request including pertinent information such as name, identification number, date and place of service, and reason for the grievance.

Clearly indicate that the written request is a grievance. This will help the Grievance Committee process the request.

Mail grievances to:

Wisconsin Division of Health Care Financing
HIRSP Grievance Committee
PO Box 309
1 West Wilson Street
Madison, WI 53701-0309

Upon receiving the request, the Grievance Committee will review the decision and either

affirm, modify, or rescind it. The Grievance Committee will communicate this decision, and the reason for the decision, in a written response within 45 days from the receipt of the request for review.

Part X. Policy Provisions

(1) **Entire Contract Changes.** This policy, the application, and any amendments are the entire contract of issuance. No agent may change it in any way. Only the *DHFS* can approve a change. Any such change must be shown in the policy or a policy amendment.

(2) **Time Limit on Certain Defenses.** After two years from the date the *policyholder* becomes covered under this policy, HIRSP cannot use misstatements to avoid coverage or deny a claim for loss that happens after the two-year period. This does not apply if HIRSP determines that the *policyholder* committed fraud or made an intentional misrepresentation that materially affects his or her eligibility or coverage.

(3) **Grace Period.** *Policyholders* can pay premiums during the 31 days after the *policy renewal date*. The policy is in force during this 31-day period.

(4) **Reinstatement.** HIRSP does not provide for the reinstatement of this policy if it lapses due to nonpayment of the premium. If the *policyholder* mails or delivers a premium to HIRSP after the grace period, HIRSP will return the premium as soon as HIRSP determines the premium is late. No agent is authorized by HIRSP to accept a late premium.

(5) **Physical Examinations.** HIRSP, at its expense, has the right to have the *policyholder* examined when and as often as is reasonable during the processing of a claim.

(6) **Misstatement of Age.** The premium for this policy is based on the *policyholder's* age. If the *policyholder's* age was misstated in the application, it may result in a change in the premium. If this policy would not have been issued at the *policyholder's* correct age, there will be no coverage under it. In such case, HIRSP will refund all premiums paid less the amount of all claims paid. If this does not cover the amount of all paid claims, HIRSP will recover the balance from the person or *provider* to whom it paid the claims.

(7) **Legal Action.** The *policyholder* cannot start a legal action to recover under the policy more than three years after the date HIRSP requires proof of loss.

This policy is signed for HIRSP by

Mark B. Moody

Mark Moody
Administrator, Division of Health Care Financing
Chairman, Health Insurance Risk Sharing Plan Board of Governors